Thomas (T. G.) Thomas

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T. GAILLARD THOMAS, M. D.,

SURGEON TO THE NEW YORK STATE WOMAN'S HOSPITAL.

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VULVAR AND VAGINAL ENTEROCELE.*

By T. GAILLARD THOMAS, M.D.,
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There are five varieties of hernia which may show themselves in the vagina and vulva:

1. Cystocele, or hernia of the bladder.

2. Rectocele, or hernia of the anterior wall of the rectum.

3. Vaginal enterocele, or descent of a portion of the small intestines into the vagina.

4. Pudendal enterocele, pudendal hernia, or descent of the small intestines into the labium majus of one or both sides; and

5. Perineal enterocele, perineal hernia, or descent of the small intestines by protrusion through the perinæum.

Were one inclined to go very fully into detail, other varieties might be given, based upon the contents of these hernial sacs, in which the ovaries, the uterus, and the Fallopian tubes, either empty or filled with the products of conception, have in exceptional cases been found; or upon some extremely rare and extraordinary development of this condition—such, for example, as one case mentioned by Burns and quoted by Sir Astley Cooper,† in which the base

* Read before the New York Academy of Medicine, December 17, 1885.

† "The Anatomy and Surgical Treatment of Abdominal Hernia," by Sir A. Cooper.

Presented by the author

of the bladder, passing down alongside of the right wall of the vagina, formed a hernia in the labium majus of that side. For practical purposes, the varieties of hernia which I have mentioned will, I think, fulfill all the requirements of the case.

As the title of this paper announces, I propose to pass by herniæ of the bladder and anterior wall of the rectum, merely with the mention of them which has been made, and to confine my remarks to descent of the intestines through the pelvic roof, and their protrusion into the labia majora, into the vagina, or through the perinæum.

Although these varieties of hernia have been known for at least a century and more, it is curious to see how very generally they have been ignored in systematic treatises upon gynæcology. And this is the more remarkable since errors in diagnosis of them are very liable to occur, and, when occurring, would put both practitioner and patient in a most deplorable position. To sustain this statement, let me refer to the most recent works upon gynæcology, which are now used as text-books by students of medicine in this country and in Europe. In the works of A. Martin, Hart and Barbour, and Emmet, no mention of vaginal and vulvar enterocele is made; in those of Barnes and Edis a mere mention is made, and in those of Courty and Thomas very short and unsatisfactory accounts are given.

Even in literature outside of systematic treatises, and in that of serial character, it is difficult to find much upon the subject. The truth of this will be appreciated from the statement that Littré and Robin, in their "Dictionnaire de médecine," published about ten years ago, quote largely, in their description of it, Sir Astley Cooper, who wrote as early as 1804.

In 1736, Garengeot was, according to A. Bérard,* the

* "Dict. de médecine," tome xxx, p. 460.

first to describe this form of hernia, and he was followed by Verdier, Hain, Sandifort, and Richter. As I have already stated, Sir Astley Cooper treated of it fully in his celebrated work upon hernia in 1804. The best account of it with which I have met is that given by A. Bérard in the "Dictionnaire de médecine," published in 1846.

Instances of this accident have been put on record by the following writers: Davis, in his "Principles and Practice of Obstetric Medicine," Levret, Gunz, Boivin and Dugès, Smellie, Fordyce Barker, and Peter Young, of Edinburgh. The last-named gentleman published a very interesting paper upon the subject in the "Edinburgh Medical Journal" for April, 1882, and put upon record a striking case which illustrates most of the important features of the lesion when occurring during parturition and soon after it. In the transactions of the New York Obstetrical Society for 1878 will be found a very able and exhaustive article upon the subject by Fordyce Barker, containing several illustrative cases occurring during pregnancy and parturition, and detailing a valuable case reported by Dr. B. A. Clements, U. S. Army, in which eight distinct attacks occurred.

Vaginal Enterocele.—This variety of the disorder consists in a descent of the intestines into the pelvic cavity, either in front of or posterior to the broad ligament of one side. As Boyer and Richter long ago pointed out, the intestines never descend directly in the median line, either anteriorly or posteriorly, on account of the intimate relations of the vagina at these points. They always descend a little obliquely, and most frequently posteriorly.

Usually the intestines alone descend in these hernial protrusions, but sometimes the omentum accompanies them; and Petrunti has reported one case in which the hernial tumor consisted of nothing but omentum. Usually, too, it is the small intestines which form the hernial protrusion, but Le-

vret * has put one case on record in which the sigmoid flexure of the colon did so, and Boivin and Dugès † mention one in which a portion of the large intestines came down as low as the perinæum and obstructed the vagina.

Vaginal hernia, as a rule, develops itself in the following manner, under the influence of causes which will soon be mentioned: A loop of intestine gradually pushes downward the prolongation of the peritonæum which forms the pouch of Douglas until it impinges upon the outside of the wall of the vagina and causes it to arch inward. This mechanical influence being continued and gradually increased, a tumor forms in the vaginal canal, inverts one wall of that canal more and more completely, and may end by escaping from the vulva and hanging outside the body, as a complete prolapse of the bladder or of the uterus would do. Under these circumstances it is evident that the tumor which protrudes has for its component parts—first, the inverted vaginal wall; second, the peritonæum; and, third, the intestines. Sir A. Cooper, in giving a description of these cases, says: "I wish it, however, to be understood that I have had no opportunity of examining this disease in the dead body, and that I am here describing it from what is known of the structure of the parts, and not from actual dissection." And Bérard, writing toward the year 1840 ‡ and declaring that it is very important to know whether "the entire thickness of the vaginal wall is inverted and forms the envelope of the tumor, or if the external coat is torn so as to present an opening through which the hernia passes, carrying before it only the internal tunic of the vagina," asserts that at that time Sandifort was the only author who had reported an autopsy, and that he had neg-

* "Observations sur les polypes," Young's article, *loc. cit.*

† "Diseases of the Uterus," p. 511.

‡ The second edition of the "Dict. de méd." appeared in 1846.

lected to mention this point. In looking up the literature of this subject, I find reports of several autopsies, and yet, so far as I have been able to ascertain, this point still remains unsettled.

Unquestionably the greatest danger which attends this form of hernia, and the same remark applies to the two other varieties which we shall consider, arises from the pos sibility of an error of diagnosis occurring from the practitioner's being off his guard, and therefore not sufficiently careful in the practice of differential diagnosis. The tumor occurring during labor and obstructing the progress of the fœtal head, a too rapid conclusion may be arrived at that an ovarian or parovarian cyst with a long pedicle has been pushed into the pelvis, a trocar and cannula are plunged in, and the operator is horrified at the escape of fæcal matter and intestinal gases. Or, if the condition be found to exist in the non-parturient woman, an effort is made to remove it, and, as this effort advances, the operator becomes painfully enlightened as to the error into which he has unfortunately fallen. Let me quote two cases to impress this important fact upon the minds of my hearers. The following is related in the "Centralblatt für Chirurgie," May, 1879: The woman, aged fifty-two, had had twelve children, the last born twelve years before. On examination, a swelling, about three inches long, reddish blue in color and covered by granulations and pus, protruded between the labia. A diagnosis of polypus of the uterus was made and the tumor removed. After suffering severe pain in the abdominal region for several hours, death ensued. Upon autopsy, there was found in the pelvis half a pound of liquid blood. A portion of the great omentum and a piece of the transverse colon had been cut away in the mass. In the posterior wall of the vagina there was an opening about five centimetres in diameter. Gunz relates the following: A woman

had a tumor occupying one wall of the vagina and presenting at the vulva. A surgeon, mistaking it for an abscess, plunged a bistoury into it, intestines protruded, and the patient died of gangrene.

The most frequent cause for the varieties of hernia which we are considering to-night is parturition. Under the influence of utero-gestation all the pelvic tissues are greatly hypertrophied and relaxed, and, under the violent efforts of child-expulsion, the relaxed parts are strained by pressure from the intestines which are forced down upon them. Nevertheless, it must be borne in mind that some of the most striking cases of the accident which have been placed on record have occurred in nulliparous women. These are usually due to violent efforts, falls, and the previous existence of pelvic tumors which have burst or been removed.

Vaginal hernia, so long as it remains in the pelvic cavity and does not interfere with parturition, is usually a matter of little moment and the source of little inconvenience. As Klebs* points out, it is not prone to undergo strangulation, for the reason that, the peritoneal protrusion having no neck, constriction does not often occur. Under certain malign influences, however, occurring during parturition, as well as in the non-parturient state, such as pressure from the fœtal head, inflammatory processes, fæcal impaction, torsion of the contents of the sac, or the existence of a neoplasm, strangulation may occur.

The symptoms which are apt to develop are difficulty in locomotion, pelvic tenesmus, or "bearing down," colicky pains, dragging sensations, tendency to constipation, and, in time, vomiting. Should the accident complicate parturition, obstructed labor is apt to result.

Upon vaginal examination, a tumor of greater or less

* "Path. Anat.," p. 970.

size is found in the vagina, and is diagnosticated by the following physical signs: It is supple, soft, and yielding; decreases upon pressure; gives a sense of gurgling to the finger if not to the ear; increases upon the patient's coughing or straining; yields resonance upon percussion, and is very generally reducible if the patient be placed in the knee-chest position and efficient taxis be practiced.

Vaginal enterocele may be confounded with the following conditions by a careless and rapid diagnostician: Prolapse of vagina, uterus, bladder, or rectum, or a combination of these displacements; with vaginal cyst, parovarian, or ovarian cyst; with a fibrous tumor presenting low down in the pelvis; with a "cold abscess" of the pelvis; or with a marked case of tubal dropsy.

It will be seen, by a review of the rational and physical signs already given, that the behavior of a true enterocele of the vagina under pressure differs very much from that which would characterize the pathological conditions just mentioned.

Why, then, it may be asked, is such caution inculcated with reference to the possibility of erroneous diagnosis?

Because error creeps in from the practitioner's being too confident, too much off his guard, and too little inclined to consider the possibility of a mistake. If he approach these cases calmly, philosophically, and in a proper spirit of diagnostic investigation, it is very improbable that an erroneous diagnosis will occur. Most cases present striking features.

Sir Astley Cooper's * description of a case seen by him is so graphic that I can not refrain from quoting it at length. The patient was "a young woman, aged twenty years, who had never had children, and whose case, I was informed by Mr. Stocker, apothecary of Guy's Hospital, was worth examination on account of a tumor projecting

* *Op. cit.*

into the vagina. She was ordered to place herself in the recumbent posture with the shoulders a little elevated, and, an examination being made *per vaginam*, I felt a swelling a little above the os externum vaginæ, the size of which was that of a small billiard-ball. It was situated at the posterior part of the vagina, but rather to the left side; it was elastic and not at all painful to the touch. When I compressed it, it readily passed away, but, upon directing her to cough, it was reproduced. When I ordered her to place herself on her knees the swelling became very tense, and much larger than before, and, when she coughed, it dilated as any other hernia, but more forcibly.

"Having placed her again in the recumbent posture, I pressed the swelling entirely away by keeping the fingers about half a minute on the posterior part of the vagina, and then carrying the fingers higher up in the vagina, above the seat of the tumor, near to the os uteri, and, having pushed the vagina toward the rectum, I directed her to cough, and the tumor was not reproduced. Still pressing at the same part, I desired her to rise, and, so long as the pressure was sustained, the hernia did not return, but almost immediately, as the fingers were removed, the hernia became as large as before."

No description could be more graphic than this as applied to hernia occurring posterior to the broad ligament.

It must be borne in mind that, like hernia occurring elsewhere, those forms which we are now considering may show themselves in two ways: first, by a brusque and sudden development marked by alarming and decided symptoms; and, secondly, by a development so gradual and uneventful as to symptoms as to escape recognition entirely until the mere mechanical results of the hernial tumor force themselves upon the attention of patient or physician. A

the end of this paper I shall relate a very striking and remarkable instance of the latter form of development. An equally striking illustration of the former is given by Dr. Young, in the article already referred to, in which all the symptoms of incarceration of the intestines rapidly and unmistakably showed themselves to be entirely relieved by successful taxis.

In certain very rare cases acute vaginal hernia occurs as a consequence of some traumatic influence destroying the continuity of this canal in its upper part. A striking instance of this, which occurred in the service of M. Auger, is reported by M. Pennel, in "La France médicale" for November, 1881. The patient, three months pregnant, endeavored to bring on abortion by the use of vaginal injections. One of these was immediately followed by violent colic, and in a few days after by abundant hæmorrhage which continued for several days. At that time a loop of intestines escaped from the vulva, which could readily be returned to the abdomen, but would at once prolapse. On the day after this occurrence the cæcum made its appearance, as evidenced by the presence of the vermiform appendix. In time this proved to be irreducible, and gangrene occurred, followed by escape of fæcal matter. During the progress of this condition abortion took place and a fœtus was expelled. In time the vaginal opening of the intestine closed entirely, fæcal matters passed normally, and the patient made not only a complete, but a rapid recovery.

Some years ago I called a consultation of two physicians in a case of interstitial pregnancy to decide the question of laparotomy. One of these gentlemen, anxious for an extremely thorough and conscientious diagnosis, refused to express an opinion until he had had the privilege of passing his entire hand into the vagina. I acceded to his wish, anæsthetized the patient, and his desire was fulfilled. As

he withdrew his hand, however, a loop of intestine escaped from the vulva through a laceration which he had made in the upper part of the vaginal canal. I at once put the patient in Sims's position, introduced a speculum, and sewed up the rent. The patient recovered after having narrowly escaped death from acute peritonitis, and my colleague the annoyance of a suit for malpractice.

I once saw a similar hernia follow an attempt to replace a retroflexed uterus by a sponge probang in the hands of a most able and cautious gynæcologist. As the retroflexed fundus was pressed upon, the sponge suddenly burst through the vagina into the peritoneal cavity, and, being withdrawn, came forth entangled in a loop of small intestine. The examiner at once sewed up the opening with silver wire, and the patient recovered without a bad symptom.

It is not so much in the acute as in the gradually developing, creeping, insidious cases that the danger of erroneous diagnosis lies in ambush for the unwary and impulsive surgeon.

Pudendal Enterocele, or Pudendal Hernia, demonstrates its existence by the presence of an elastic tumor, about as large as a small hen's egg, or a pigeon's egg, about the middle of the labium majus of one side.

It may originate in two ways. As Paul Broca * has fully pointed out, the round ligaments of the female, which are the analogues of the spermatic cord of the male, after passing down through the inguinal canals, lose themselves in two glove-finger prolongations of fibrous character, which run down through the labia majora. Following the course of these ligaments through the abdominal rings and the inguinal canal the intestines sometimes descend, as they do along the spermatic cord in getting to the scrotum, and

* Cruveilhier's "Anatomy," chapter "External Organs of Generation."

reach their ultimate point of descent in these dartoid sacs. Again, they sometimes reach the pudendum by passing downward between the vagina and the ramus of the ischium, thus reaching the labium majus from within the pelvis. In its commencement the latter variety resembles exactly vaginal hernia; but, instead of inverting the vagina before it as that does, it separates the vaginal wall from the ischium and insinuates itself between these parts.

Some of the French writers* divide hernia of the labia majora, or pudendal enterocele, into two varieties: first, "anterior labial hernia," or that which eventuates from the inguinal form; and, second, "posterior labial hernia, or labio-vaginal hernia," or hernia forming by extension of the peritonæum down in front of the broad ligament and alongside the vagina to the vulva.

From inguinal hernia ending by descent into the labium majus the internal variety may be thus distinguished: (1) the finger, pushing the tumor upward, will pass into the pelvic cavity between the ischium and vagina; (2) at the level of the os uteri, or thereabout, it will enter the pelvic roof; and, (3) pressure being maintained on the inguinal canal, and the patient being ordered to cough, it will, in spite of the pressure, recur.

In diagnosis the following conditions of the labia majora may be confounded with pudendal hernia:

Cyst or abscess of the vulvo-vaginal gland;

Cyst of the labium minus, or majus;

Abscess of the labium majus;

Fatty or fibrous tumor of the labium;

Tumors descending from the pelvic cavity.

Dr. Galabin reports, in the "Transactions of the Obstetrical Society of London" for 1884, what he believed to be a hydrocele, an egg-shaped cyst, two inches and a half long,

* De Sinéty, "Manuel pratique de gynécologie."

translucent, occupying the labium majus. It had existed three years in a patient aged fourteen, been tapped once, and a straw-colored fluid removed. Dr. Galabin divided the skin on a director, and found a cyst free except at the anterior end toward the inguinal ring, where a firm cord was divided. The patient recovered.

Saenger (in "Arch. für Gynäkol.," vol. xvi) reports two cases in which the contents of labial herniæ were found to be tumors of the broad ligaments. In one case, reported by Hecker, the woman, aged forty, had noticed since childhood a tumor situated in the right labium majus. This mass, formerly easily returned into the abdomen, was at the time of operation irreducible. An incision was made over the tumor, which was found to be a myoma of the ligamentum rotundum; weight, three hundred and thirty grammes.

Paletta reports a case which was similar, a fibro-myoma of the round ligament being found as the contents of a labial hernia.

The differentiation of pudendal hernia from these conditions of the labia should be very carefully considered, for, if an erroneous diagnosis be made here, a fatal result might very probably prove the consequence.

The diagnostic signs which prove most reliable, and which may almost be styled pathognomonic, are these: First, airy feeling upon palpation; second, gurgling upon replacement; third, diminished tension in the dorsal decubitus; fourth, diminution of bulk upon taxis; fifth, resonance upon percussion; sixth, succussion upon coughing; and, seventh, intestinal pains of a colicky character.

As I have already said in reference to vaginal enterocele, there are no very great difficulties attending the differentiation of the disease. The danger is that the possibility of hernia at this point may be forgotten, and deductions

drawn without considering it. Although the probability of error be not great, the appalling nature of the accident in which it would result warrants the relation of the following case, which is illustrative of its possibility: A patient called upon me with the following history: She had had an abscess just below the external abdominal ring, which, after poulticing, had been evacuated by her physician about a month before the time of her visit to me. After this she had felt well until a week before, when, after a muscular effort, the pain had returned with all the original signs of abscess, and these had continued, although she had painted the part steadily with tincture of iodine, as she had been directed to do in case of such an occurrence. Being in great haste at the moment, I examined the enlargement while the patient was standing, and, under a recent cicatrix which was painted with iodine, I discovered what I supposed to be a reaccumulation of pus. As the patient came to me, in the absence of her physician, merely for the evacuation of this, I placed her in the recumbent posture, and, lancet in hand, proceeded to operate. But, to my surprise, I discovered that change of posture diminished the size of the enlargement. This excited my suspicions, and, upon further examination, I found that a recent hernia had occurred under the old cicatrix.

Perineal hernia may affect both male and female. In the latter it consists of the descent of the intestines between the vagina and rectum, the advance being made posterior to the broad ligament, and continuing until the perineal muscles are forced apart, and the gut, with its peritoneal envelope, is arrested by the skin. In these cases Sir Astley Cooper declares that the hernial sac "protrudes as far as the skin of the perinæum, but does not project it so as to form an external tumor; its existence in the male can be only ascertained during life by an examination by the

rectum; but in the female it may be felt both by the rectum and by the vagina. The sac lies between these two canals."

All these varieties of hernia are usually readily amenable to taxis, and this I have invariably in my experience found greatly facilitated by the knee-chest, or genu-pectoral, position. In some rare cases strangulation occurs. Under these circumstances the same surgical practice is indicated as in inguinal or crural hernia—namely, cautious opening of the sac and section of the constricting band by passing up a probe-pointed bistoury.

Before closing this paper, I desire to put upon record a remarkable case of extreme vaginal hernia, which presents some features which I have never met with in such literature of the subject as has fallen under my observation:

Mrs. K., a multipara of small figure and spare habit, thirty-nine years of age, residing in Middletown, Conn., called upon me in my office, and gave me the following history: About six years ago she noticed that a lump presented itself at the vulva, and that she began to suffer from difficulty in locomotion, frequent micturition, painful defæcation, dragging in the back and loins, colicky pains in the bowels, and general nervousness and malaise. During the past six years this tumor had steadily increased in size, until it had come down to the middle of the thigh on the right side. At the time I saw her she was greatly emaciated, and suffered so much from the symptoms which have been enumerated that she felt that any resource which held out the prospect of even partial relief would be a boon to her. While the tumor hung out of the pelvis, she could neither stand, walk, nor sit with any comfort, and when by taxis it was restored to the pelvis, she found it so very difficult and painful to empty the bladder and rectum that she was compelled voluntarily to force it out again.

Upon physical examination, as the patient lay upon the back, I discovered a large pinkish-colored tumor hanging from

the vulva, as represented in Fig. 1, and presenting all the gross appearances of a huge cystocele. As soon as a minute exami-

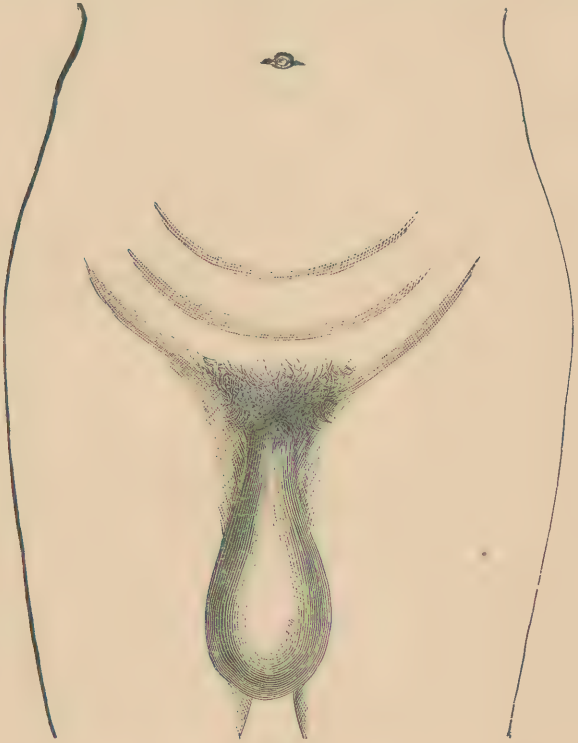

FIG. 1.

nation was made it at once became evident that this superficial impression was entirely erroneous. The index-finger being passed around the tumor and up the vagina, the tumor was found to be attached to the ischium on the right side of the vulva, so that there was no vaginal space there at all, while on the left side it passed up readily and discovered the uterus almost out of reach in the left side of the pelvis. A catheter

being passed into the bladder, that viscus was found high up above the pubes and obliquely in front of the uterus.

Taxis being practiced in the knee-chest position, the tumor disappeared with a very slight gurgle, its contents evidently retreating into the pelvis through an opening on the right side. Only once in manipulating the mass did a slight gurgling sound make itself manifest; resonance upon percussion did not appear

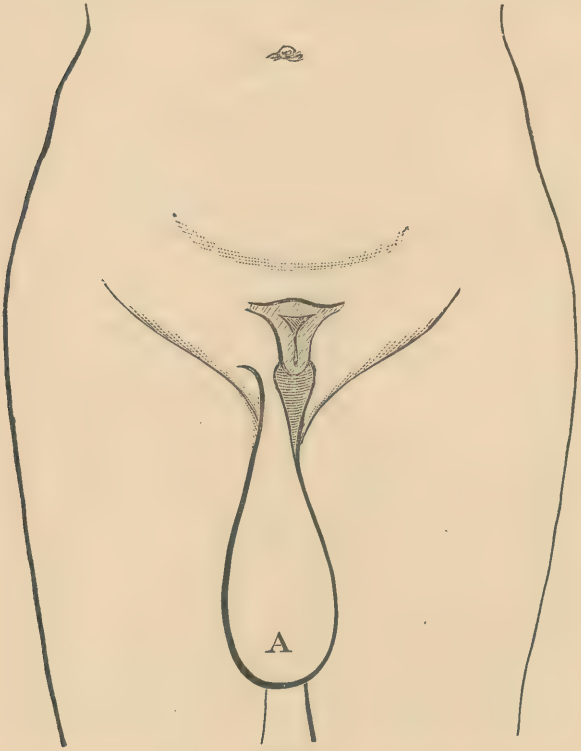

FIG. 2.

distinctly, and yet there could be no doubt that hernia did exist. After the contents of the sac were returned to the abdomen it

was evident that their retention there, or even the retention of the sac itself within the pelvis, would prove impossible by any mechanical contrivance which could be devised, for two reasons—first, the great weight of the mass; and, second, the fact that pressure of it against the bladder and rectum when it was returned to the body interfered so greatly with the functions of these viscera as to render the patient utterly uncomfortable.

And yet the deplorable condition of the patient and her

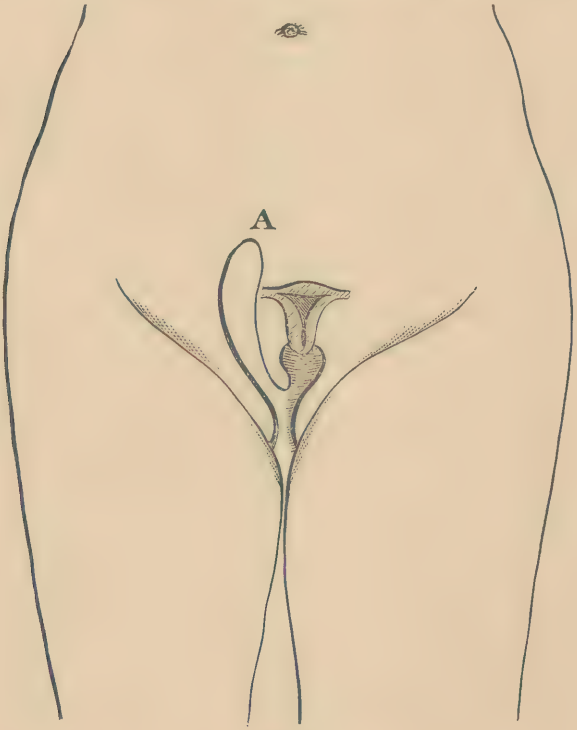

Fig. 3.

great mental and bodily distress urgently called for active interference. She had consulted many medical men, had been dis-

couraged from seeking surgical relief, while all lesser methods had failed to give her aid, and now both she and her husband were desperate, and willing to adopt any plan which held out the least hope for them.

It was under these circumstances that I suggested the following operation: I proposed to perform laparotomy; cause an assistant to keep the hernial sac well within the pelvis by one

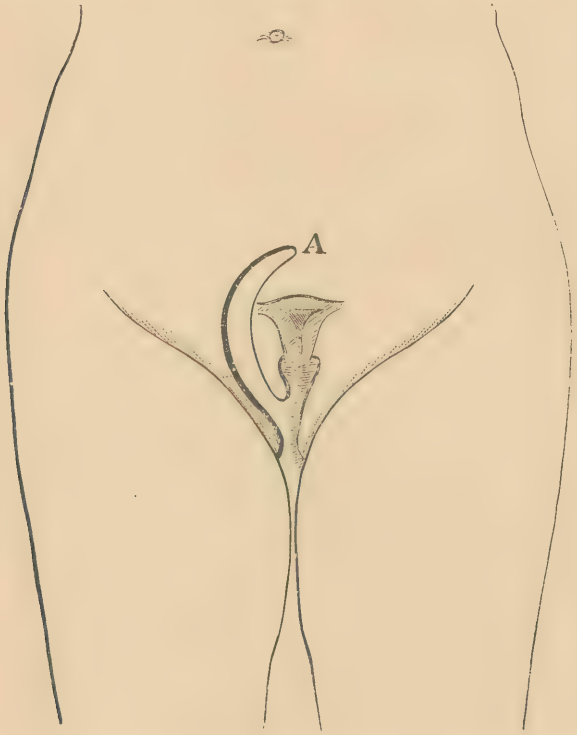

Fig. 4.

hand in the vagina; pull all the contents out of the sac; seize this at its most dependent portion (A, Fig. 2), drag it up into

the abdominal wound (Fig. 3), and fasten it there by suture, sustaining the heavy sac, meanwhile, by two knitting-needles passed through and lying flat across the abdomen (Fig. 4).

As soon as this was explained to them they eagerly accepted the proposal, and the patient entered my service in the Woman's Hospital. There Dr. Emmet and Dr. Bozeman saw her with me, agreed in the diagnosis, and indorsed the operation proposed.

Upon cutting through the abdominal wall, after an assistant had, as I have stated he was to do, pushed the hernial mass back into the pelvis, I was surprised to find in the pelvis a soft, fibrous tumor, which had evidently been pushed up from below, on a level with the symphysis pubis. It was very movable, covered by peritonæum, disconnected with the uterus, and, upon careful examination, proved to have no connection with the bladder. I was entirely at a loss to determine its relations, but, in view of the desperate character of the case, decided at once to remove it. This I did by splitting the peritoneal covering, tying a number of bleeding vessels, draining the sac with a glass tube, and fastening the sac into the abdominal wound, as I have said that I proposed to do. The patient made a good recovery, and so far, more than a month having now passed since the operation, has continued to be free from any return of the hernia. I confess that I feel apprehensive about the future, but the present is quite gratifying and completely satisfactory.

My explanation of the case is this: This very movable tumor, which appeared to have no fixed anchorage in the pelvis, had originally pushed the vagina before it by entering the pelvic cavity behind the broad ligament of the right side; the intestines had pressed down upon this, and together they had made up the contents of the sac.

And now the question suggests itself, What was the nature of this tumor? Dr. Coe, the pathologist of the Woman's Hospital, has furnished me the following report of his examination of it:

"*Report on Specimen removed by Dr. Thomas at the Woman's Hospital, November 12, 1885.*

"*Gross Appearance.*—A soft, shapeless mass of tissue, which bears a certain resemblance to an hypertrophied bladder.

"Weight, 10 ounces.

"Measurements, 22 × 15 ctm.

"Average thickness, 1·5–2 ctm.

"The growth is covered in some places by a layer of peritonæum, and over its exterior are numerous torn pieces of tissue, marking the sites of adhesions. The vascular supply of the exterior of the mass is quite extensive, but its interior is bloodless and poor in vessels.

"On section, no signs of cyst-formation can be found; nothing but a softened, œdematous, fibrous tissue. This tissue is easily separated by the fingers so as to form pseudo-cavities, but no true, preformed cavity is present anywhere.

"The tissue varies in color at different points. On holding the mass up to the light, it is seen to be traversed by bundles, or trabeculæ, of reddish fibers (smooth muscle?), which offer a contrast to the general whitish ground of the tumor.

"*Microscopically*, (1) The growth consists of ordinary fibro-muscular tissue, similar to that of a uterine myo-fibroma. Vessels are few in number.

"(2) The fluid squeezed from the interstices of the tissue is colorless, and contains no cellular elements, except a few blood-corpuscles (lymph?).

"(3) The tissue, covering the exterior of the growth, is a delicate membrane, strengthened by interlacing fibers of connective tissue, in the meshes of which are numerous large, epithelioid cells. Nerve-fibers and blood-vessels cross the field in all directions.

"*Inferences.*—(1) This is not an organ, *i. e.*, the bladder.

"(2) It is not an ovarian cyst.

"(3) It is not composed (at least to any great extent) of inflammatory tissue.

"What is it? I submit two theories, both of which are merely theories—viz,:

"(1) The growth is a local hypertrophy of the pelvic connective tissue.

"(2) It is a sub-peritoneal uterine fibroid, which has become thoroughly œdematous.

"I incline to the former view for the following reasons:

"1. The situation of the mass at the time of operation, as described to me.

"2. The absence of a distinct pedicle.

"3. The absence of a complete peritoneal covering.

"4. The absence of any 'géodes,' or cavities, in the mass, such as are almost invariably found in a softened fibroid.

"Finally, the *tout ensemble* of the tumor, which forbids the thought that it has ever been a firm, hard growth, such as a fibroid.

"*Origin of the Growth.*—The presence of adhesions, in which the mass was buried, the dilated condition of the blood-vessels in those adhesions, and the general œdema of the tissue, all point to some obstruction of the circulation in the tumor. It is not difficult to regard this phenomenal appearance as due to simply a localized œdema of the pelvic connective tissue."

(Signed) H. C. Coe.

That this tumor had no connection whatever with the uterus or bladder I feel quite sure. My impression is that it belongs, as Dr. Coe's report intimates, to a somewhat rare class of tumor, arising from the pelvic areolar tissue or the round ligaments, of which quite a number have been recently reported by German pathologists.

Dr. McCosh has kindly looked up the subject for me, and I present some of his researches.

A. Martin, in his recent work upon the "Diseases of Women," says: "In the broad ligaments are to be found, also, solid tumors which are described as myoma or fibromyoma. They are not connected with the uterus, but spread out between the epithelial layers of the ligamentum latum, and can from that point develop as large abdominal tumors, or may grow downward toward the vagina, and, finally, at

the side of the vagina, bulge out as far as the vulva, where they present themselves for operation. In rare cases they have pushed through the great ischiadic foramen."

The same author also reports the case of a woman who complained of great weight and vaginal pressure. On examination, he found a prolapsus of the anterior vaginal wall, and also of the posterior, Douglas's pouch being filled with a soft mass which seemed to arise on one side of the uterus. He performed laparotomy, and found the mass to consist of an œdematous fibro-myoma of the broad ligament.

Schmidt reports a case of a solid tumor attached by a pedicle to the broad ligament, which caused marked prolapse of the anterior vaginal wall.

Schröder acknowledges the existence "of connective-tissue tumors, of very soft consistence, which are saturated with fluid, and which arise in the pelvic connective tissue, and in this situation (subserous) continue to develop.

"Their anatomical relations correspond to subserous ovarian cysts," etc.

M. Hofmeier ("Gesellsch. f. Geb. und Gyn.," Berlin, October 24, 1885) reports a tumor, of the size of the fist, situated between the anterior vaginal wall and the urethra, causing a decided prolapse, and projecting above the level of the vaginal wall to the size of an egg, the spot being somewhat ulcerated. After division of the capsule, it was easily enucleated. Its attachment was deep in the connective tissue of the pelvis; and it belonged to the rare class of soft fibroid tumors of pelvic connective tissue.

It is highly probable that the tumor which I removed belonged to one of these curious and rare classes.

Unfortunately, little can be said concerning the treatment of vaginal and vulvar herniæ, for the reason that there is but one variety, the pudendal, which eventuates from in-

guinal hernia, for which very much can be done. That variety is as amenable to treatment by the ordinary truss as inguinal hernia is. The other varieties can, to a limited degree, be relieved by pessaries, perineal pads, abdominal bandages, etc.; but we are poor in methods of decided relief, and utterly wanting in those of cure. It appears to me that the plan suggested, and partially carried out in the case which I have related, promises more than any other which has yet been brought forward; but of the validity of this surmise time and experience must give the proof. Certain I am that, if another case of large vaginal hernia presented itself, I should feel inclined to try laparotomy, dragging up the sac and fastening it in the abdominal wound.

B. Schmid says ("Handbuch f. Chir.," Billroth und Pitha) that attempts were made by Huguier at radical cure of vaginal hernia by an oval excision of part of the posterior vaginal wall and closure by suture, but without any lasting result. He must, indeed, be a sanguine surgeon who hopes for much from such procedures.

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